Cleveland Clinic
School of Diagnostic Imaging

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SCHOOL OF DIAGNOSTIC IMAGING

COMPUTED TOMOGRAPHY (CT) / MAGNETIC RESONANCE IMAGING (MRI) PROGRAMS APPLICATION FOR ADMISSION

Print or type all information below. **Please include your legal name only.**

PERSONAL DATA

Last Name _____ First _____ Middle _____
Maiden _____
Address _____ City _____ State _____ Zip _____
Home Phone Number _____ Work Telephone Number _____
Cell Phone Number _____ E-Mail Address (Required) _____

Admittance is on a first come, first serve basis until course is filled. Please indicate which program and/or course(s) you are applying for as well as your availability (check all that apply):

PROGRAMS	CHECK HERE
MRI Program (including 400 clinical hours)	
CT Program (including 400 clinical hours)	
If intending to complete both CT & MRI programs, please indicate which program you will participate in first.	□ CT Program first □ MRI Program first
INDIVIDUAL COURSES ONLY	
Introduction to CT / MRI	
Cross Sectional Anatomy and Pathology I and II	
MRI Physics	
CT Physics	
CT or MRI Clinical Course (Circle One)	

A $20 non-refundable application fee must accompany this form.

GENERAL

How did you become aware of School of Diagnostic Imaging's CT/MRI Program?

□ Brochure □ Internet □ Former Student
□ Friend/Relative/Co-Worker □ Phone Book □ Newspaper
□ Other: please explain _____

IMPORTANT INFORMATION

If you have a record of criminal conviction of a crime, including a felony, alcohol and/or drug related violations, a gross misdemeanor or misdemeanors with the sole exception of speeding and parking violations, criminal proceedings where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered, or a criminal proceeding where the individual enters a plea of guilt or nolo contendere, military court-martial that involves: substance abuse, sex-related infractions or patient-related infractions, or have pending litigation, these conditions may prevent an applicant from becoming registered. These applicants are encouraged to contact the American Registry of Radiologic Technologists at (651) 687-0048, or at www.arrt.org to determine examination eligibility.

FOR SCHOOL OF DIAGNOSTIC IMAGING USE ONLY

Date Application Submitted: _____
Acceptance Letter Sent: □ Yes □ No
ARRT Card: □ Yes □ No
BLS for Healthcare Provider □ Yes □ No
Date Application Complete: _____

Application Fee Paid: □ Yes □ No
In Grad Pro: □ Yes □ No
Acceptance Fee Paid: □ Yes □ No
In Roster □ Yes □ No
Initials: _____

EDUCATION

POST SECONDARY EDUCATION: List all education beyond high school (include all courses in which you are currently enrolled).

DATES FROM	TO	NAME OF INSTITUTION	CITY/STATE	MAJOR	DIPLOMA/DEGREE

EMPLOYMENT HISTORY

YEARS FROM	TO	NAME OF COMPANY/INSTITUTION	CITY/STATE	POSITION

REGISTRATION INFORMATION

You must have current ARRT or equivalent registration and BLS for Health Care Provider. Documentation will be required upon acceptance into the program.

Are you a registered technologist? ☐ Yes ☐ No

If you **are** a registered technologist, in which modality are you currently registered?

☐ Radiography ☐ Nuclear Medicine ☐ Ultrasound ☐ Radiation Therapy

Please include a copy of your ARRT or equivalent card

If you are **not** a registered technologist please provide imaging program transcripts and indicate the date you intend to take the registry: _____

AGREEMENT

PLEASE READ CAREFULLY - APPLICANT'S CERTIFICATION AND AGREEMENT

I certify that all my answers and statements herein are complete and true. I understand that any falsification or omission may cause my application to be rejected, or my enrollment to be terminated. I realize that failure to successfully complete a physical examination may cause my application to be rejected or my enrollment to be terminated. I agree that nothing in this application for the School of Diagnostic Imaging, or said to me, or contained in the written materials given to me, is intended to be an offer or promise or agreement by the School of Diagnostic Imaging or the Cleveland Clinic to enroll me for any specified period of time.

Signature of Applicant _____ Date _____

Cleveland Clinic does not discriminate in admission, employment, or administration of its programs or activities, on the basis of age, gender, race, national origin, religion, creed, color, marital status, physical or mental disability, pregnancy, sexual orientation, gender identity or expression, genetic information, ethnicity, ancestry, veteran status, or any other characteristic protected by federal, state or local law. In addition, Cleveland Clinic administers all programs and services without regard to disability, and provides reasonable accommodations for otherwise qualified disabled individuals.